TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Melburn K. Huebner, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-2329-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting that you reconsider this for payment. **This was requested by the Designated Doctor for an IME to address surgical intervention, extent of injury and determine if additional treatment is medically necessary.** The bill has been corrected. I have enclosed copies of my notes on this claim. I have enclosed copies of the guidelines per Chapter 130, Paragraphs 3 & 4 and another copy of his evaluation. **The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement ($350.00) plus the reimbursement for the body area(s), see Section 4 C, evaluated fro the assignment of an IR, the first body are is $300.00.** The rate for RME's is $500.00. We bill from the guidelines and as this is a work related injury we do not accept the usual and customary deductions or any PPO deductions as we are not under any contracts."

Amount in Dispute: $577.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of **11/5/2014.**

The requestor apparently received a referral from the designated doctor, Amy Kirsch, D.C., for additional information and testing of the claimant. The issue is that the requestor billed with code 99456RE. The requestor was asked for additional information not to make a designated doctor determination regarding return to work. Further, the testing performed is not reimbursable as billed because of the primary code used, 99456RE.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2014	Specialist Examination Requested by A Designated Doctor	$577.00	$48.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
4. 28 Texas Administrative Code §127.10 sets out the general procedures for Designated Doctor Examinations.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   For CPT Code 99456-RE:
   - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - 714 – Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/i 95 days from DOS.
   - 892 – Denied in accordance with DWC Rules and/or Medical Fee Guideline including current CPT Code descriptions/instructions.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.
   - 18 – Exact duplicate claim/service.
   - 736 – Duplicate appeal. Network contract applied by Texas Star Network.

   For CPT Code 95834:
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217 – The value of this procedure is included in the value of another procedure performed on this date.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.
   - 18 – Exact duplicate claim/service.
   - 736 – Duplicate appeal. Network contract applied by Texas Star Network.

   For CPT Code 95851:
   - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.
   - 18 – Exact duplicate claim/service.
   - 736 – Duplicate appeal. Network contract applied by Texas Star Network.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment for CPT Code 99456-RE supported?
2. Are the insurance carrier's reasons for denial or reduction of payment for CPT Code 95834 supported?
3. Are the insurance carrier's reasons for denial or reduction of payment for CPT Code 95851 supported?
4. What is the total allowable for the payable disputed services?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed service 99456-RE with claim adjustment reason code CAC-P12 – "Workers' Compensation Jurisdictional Fee Schedule Adjustment." 28 Texas Administrative Code §134.204

(k) states, in relevant part, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. **When conducting a Division or insurance carrier requested** RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE'" [emphasis added].

Review of the submitted information finds that the examination in question was requested by a designated doctor, not the Division or insurance carrier. Therefore, the insurance carrier's denial of payment for CPT Code 99456-RE is supported.

2. The insurance carrier denied disputed service 95834 with claim adjustment codes CAC-97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 217 – "The value of this procedure is included in the value of another procedure performed on this date."

   28 Texas Administrative Code §134.204 (k) states, in relevant part, "Testing that is required shall be billed using the appropriate CPT codes and reimbursed **in addition to the examination fee**." Further, 28 Texas Administrative Code §127.10 (c) states, in relevant part, "The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title."

   Therefore, the insurance carrier's denial of payment for CPT Code 95834 is not supported and payment will be reviewed according to the appropriate fee guidelines.

3. The insurance carrier denied disputed service 95851 with claim adjustment code CAC-P12 – "Workers' Compensation Jurisdictional Fee Schedule Adjustment." 28 Texas Administrative Code §134.203 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; **correct coding initiatives (CCI) edits**; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules" [emphasis added].

   Per Medicare policy, procedure code 95851, service date November 5, 2014, may not be reported with the procedure code 95834 billed on this same claim. Therefore, the insurance carrier's denial of payment for CPT Code 95851 is supported.

4. Procedure code 95834, service date November 5, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.6 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.6. The practice expense (PE) RVU of 0.81 multiplied by the PE GPCI of 0.916 is 0.74196. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.816 is 0.02448. The sum of 1.36644 is multiplied by the Division conversion factor of $55.75 for a MAR of $76.18. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $48.00.

5. The total allowable reimbursement for the services in dispute is $48.00. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $48.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $48.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $48.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 13, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.